Behavioral Health Reform - Frequently Asked Questions, March 2005

1. **Phase I underestimates the length of time in treatment necessary to address many of the issues consumers have when coming to the Regional Centers. Twenty-six days of treatment (5 days of acute, 21 days of subacute) is often an inadequate length of time to address the multiple problems associated with the illnesses that consumers have when they are referred to treatment at the Regional Centers, particularly for those who have refractory illnesses or do not fall into the categories covered by the Medicaid Rehab Option funds.**

   The plan takes into account that if a consumer has not responded to treatment after 25 - 30 days in a community based psychiatric hospital, they will probably need a significantly longer stay. That stay may be in a sub-acute program, it may be in residential care, or it may be in a general psychiatric bed at a Regional Center.

2. **The plan lowers the quality of behavioral health care by "deprofessionalizing" services. Psychiatry is limited largely to a distant supervisory role. Consumers will have difficulty obtaining services from licensed mental health professionals and psychologists, except for inpatient services.**

   On the contrary, the plan improves the quality of behavioral health care. Under the supervision of physicians, individuals with bachelors or masters degrees currently provide the majority of the care in the community. In the regional centers, the majority of direct client contact is with psychiatric technicians. Qualified mental health professionals are a part of every community service component under behavioral health contracts.

3. **The plan lowers the quality of behavioral care by assuming that all consumers can be successful with "less intensive services in community-based settings". The reality is, many consumers currently served by the Regional Centers have repeatedly failed in community-based programs.**

   HHSS is currently contracting with the regional authorities to develop transition teams. These teams include staff from several community agencies, a consumer, and staff from the regional center. Together with the consumer, these teams are evaluating the consumer strengths and needs, and begin to develop a plan for the kinds of community services that meet the consumer needs and wishes.

   The transition team evaluations will continue to evaluate needs, risks, and the capability of community programs to serve individuals. Meanwhile, services are improving as new programs are developed and staff gain experience and training. The transition team process will also help wrap services from more than one agency around a consumer to help ensure that all facets of that individual's recovery are supported. Given all of this, however, there is no assumption that every person can always be served in the community.

4. **The plan does not expand services to those in need. Except for the "crisis response team", which is an unknown quantity, the LB 1083 Behavioral Health Implementation Plan features few new services.**

Crisis Response Teams (also known as the "Memphis model") are evidence based programs, and have significantly decreased hospitalizations in those areas around the country in which they have been implemented. The keys to success of these community services will be the coordination and integration between providers, intensity of services, training, and planful implementation, which the Crisis Response Teams will provide.

5. **The plan does not meet the needs of most people currently in the Regional Centers. Most consumers are in the Regional Centers not because of the acute nature of their symptoms, but because of their inability or unwillingness to seek care. The plan does not recognize this.**

   People who are hospitalized for reasons other than the acute nature of their symptoms are the same individuals who can best be helped by community based services. These individuals do not need to be and should not be hospitalized.

6. **The need for long-term care for many consumers has been excluded. The plan assumes that those people can be served by nursing facilities through Medicaid funds. The reality is that many consumers do not pass federal screening for long-term (OBRA). Of those who do pass the screening, many have been refused services because of problem behaviors that create peril for other consumers considered vulnerable.**

   There has been confusion between the idea of specialized long-term care, which means nursing home care in this context, and care for the long-term. HHSS assumes that there are fewer than 26 individuals in the regional centers who meet the requirements for long-term nursing home care. In order to deal with the problem behaviors of some of these consumers, the state is developing a new level of nursing home care, called "Intermediate Specialized Services (ISS)."

   These are specially funded nursing home beds for individuals who do meet the OBRA requirements for long term care and who also are seriously mentally ill and in need of additional behavioral health care. For individuals who do not meet OBRA requirements but require care for the long-term, a wide variety of options are being developed including assisted living facilities, psychiatric rehabilitation facilities, ACT teams, etc.

   HHSS is currently contracting with the regional authorities to develop transition teams. These teams include staff from several community agencies, a consumer, and staff from the regional center. Together with the consumer, these teams are evaluating the consumer strengths and needs, and begin to develop a plan for the kinds of community services described above, including the Intermediate Specialized Services facilities.

   HHSS is also negotiating with the University of Nebraska Medical Center to develop a screening instrument for the ISS facilities, and eventually all of the geriatric or physically impaired residents of the hospital will be screened by geriatric psychiatrists for the appropriate level of care.

7. **The plan relies on increased Medicaid funding; however, the future of Medicaid funding is tenuous. The federal government has attempted to cut funding in the recent past and is likely to continue this path in the future.**

The plan does rely on increased Medicaid funding, but not entirely. The state will always have a role to play in paying for services for persons with serious mental illness. Medicaid funding may, in the future, be capped at some level, and it may decrease some, but it will always be supplemented by state dollars.

8. **The Regional Centers serve people who fall through the cracks of Medicaid funding. Medicaid Rehab Option funds are restricted to people with severe and persistent mental illnesses; many people who are served by the Regional Centers do not fall into this category. Eliminating the safety net of the Regional Centers for these consumers will leave them with no services.**

   There are individuals at the regional centers who do not meet the criteria for the Medicaid Rehabilitation Option because they do not meet the disability requirements for eligibility, or they do not meet the income requirements. This is an additional reason that state funds support each program that cares for these individuals in the community -- so that individuals without Medicaid can continue to be served. Anybody at a regional center should be eligible for the Medicaid Rehab Option as having a severe and persistent mental illness. There have been no denials for MRO service authorization for at least the last six months.

   If an individual has a generic diagnosis (Schizophrenia: Not Otherwise Specified, for instance) they receive services for 30 days, during which time the diagnoses is reviewed and rehabilitation and support needs are assessed.

9. **The plan provides no real method in which the state can be held accountable for deficiencies in services that disrupt public safety. The state needs to provide more than mere assurances to communities that there will be adequate services and that public safety will be maintained. What happens if those assurances prove false? Who is accountable? There also must be a method provided in the plan for information regarding the effectiveness of community-based programs.**

   The State is always responsible for the safety of its citizens, including those with disabilities such as mental illness. Nebraska is being careful that community based services reflect the rights and concerns of consumers and are based on science and proven efficacy. There is a misconception that most people in the regional centers are there because they are potentially violent. On the contrary, people are often committed because they are dangerous to themselves, which includes not being able to care for themselves.

   A tracking program is being developed in collaboration with the University of Nebraska Medical Center for the individuals currently in the regional centers. Staff from UNMC will be monitoring services and outcomes for people leaving the hospitals in the coming year.

   The State is currently developing methods for improving the oversight of community services and choosing measures, including those that reflect impact on public safety, by which to evaluate success of the plan. As reform moves forward, the State is developing

quality assurance mechanisms and choosing measures, including those that reflect impact on public safety, by which to evaluate success of the plan. Providers are credentialed and are monitored by regional authorities and state staff.

10. The plan underestimates the need for dual diagnosis treatment. Sixty percent of consumers have co-occurring chemical dependency problems and mental illness. Two additional residential programs (20 beds) will not meet their needs adequately.

A very high number of individuals with a serious mental illness have a co-occurring substance abuse diagnosis. A large number of people seen in addictions treatment programs have co-occurring mental illnesses. The extent of the overlap of these two problem areas is such that all programs that treat one must be able to treat the other. Standards require Assertive Community Treatment teams to serve co-occurring disorders. Additional emphasis will be placed on this ability in all programs. The additional residential programs will be available to serve those individuals with the most intransigent problems.

11. The plan does not specifically address the law enforcement burden for locating consumer services. Historically, law enforcement has had two responsibilities in mental health crisis: (1) responding to the incident that endangers the consumer or others; and (2) obtaining treatment for consumers. The "urgency" of the second instance is on the law enforcement officer.

Crisis Response Teams, now being planned for all regions of the state, specifically address this issue. Behavioral Health Professionals go with law enforcement to evaluate the person in crisis. Team members collaborate on the spot and many times an EPC can be avoided altogether. Crisis response teams are partnerships between behavioral health and law enforcement, and include specialized training for both parts of the team. In addition, LB1083 included $2.5 million yearly to enhance emergency services statewide.

For another view of law enforcement's perspective on crisis response teams, go to the Memphis police web site at http://www.memphispolice.org/communit.htm#crisis%20intervention%20team%20%20(CIT).